MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

02934

Reg. Diat. No. 2040

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown (R.F.D. *Fairlee)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: near - Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna Atkinson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Charles Atkinson

6.(c) If alive, give age: living years

7. Birth date of deceased (mo., day, yr.): April 30, 1882

8. AGE: Years	Months	Days	If less than one day
64	II	3	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: William Krach
13. Birthplace: Germany

MOTHER
14. Maiden name: Charlotte Lamm
15. Birthplace: Germany

16. Informant: Mr. Charles Atkinson
Address: Chestertown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 6, 1947 (month) (day) (year)

Cemetery or crematory: Saint Paul Cem.

Location: near - Chestertown, Maryland

18. Funeral director: J. Willis Wells
Address: Chestertown, Maryland

19. Mar. 6 1947 (Date rec'd by registrar) F. O. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 1947, at 6:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 23 1947, to March 3 1947 and that I last saw h[illegible] alive on Feb 28 1947

Immediate cause of death	DURATION
Chron. Endo-Myocarditis	
Decompensation	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall Md. Date signed 3/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

CERTIFICATE OF DEATH

02935

Reg. Dist. No. 202C

1. PLACE OF DEATH: Kent

County.....

City or town..... Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 days

Hospital, Institution, or street address where death occurred:

Kent and Queen Annes

How long in hospital or institution? 39 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Rural 3 - Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Quaker Neck Way

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME William Benjamin Franklin Cranor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Elizabeth Ellen Cranor

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) June 6, 1871

8. AGE: Years	Months	Days	If less than one day
75	9	2	.....hrs. .....min.

9. Birthplace Fairlee Kent, Maryland (Town, county, and state)

10. Usual occupation Waterman

11. Industry or business Oyster.

FATHER

12. Name Charles E. Cranor

13. Birthplace Queen Annes County, Maryland

MOTHER

14. Maiden name Mary Virginia Butler

15. Birthplace Kent County, Maryland

16. Informant Hospital Records

Address Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 16, 1947 (month) (day) (year)

Cemetery or ~~crematory~~ St. Johns Catholic Cemetery

Location Pulp Hall, Kent Co. Md.

18. Funeral director Marvin V. Williams

Address Chestertown, Maryland.

19. March 9, 1947 (Date rec'd by registrar) Clara S. Barnes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1947 at 11:42 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 29 1947 to March 8 1947

and that I last saw him alive on March 8 1947

	DURATION
Immediate cause of death: Circulatory collapse	12 hrs.
Chronic Myocarditis	2 years
Due to Hypertension	Unknown
Due to Arterioscelerosis	Unknown
Other conditions Cancer of colon	12 mos. P

(Include pregnancy within 3 months of death)

Major findings of operations Cancer of recto sigmoid colon Date of op. 3-5-47

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury Injured at work?

23. SIGNATURE A. C. Dietz M. D. or other

Address Chestertown, Md. Date signed 3-8-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

02936

Reg. Dist. No. 2020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred:
Kent & Queen Anne's Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural #1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Carrie Elizabeth Hicks

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	married

6.(b) Name of husband or wife: Clyde D. Hicks
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): Aug 30, 1889

8. AGE: Years	Months	Days	If less than one day
57	7	22	....hrs. ....min.

9. Birthplace: Winchester, Frederick Co., Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: James E. Lewis
13. Birthplace: Winchester, Va.
MOTHER 14. Maiden name: Jennie V. Bowers
15. Birthplace: Winchester, Va.
18. Informant: Clyde D. Hicks
Address: Chestertown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 10, 1947 (month) (day) (year)
Cemetery or crematory: Chesters Cemetery
Location: Chestertown, Md.
18. Funeral director: B. R. Fullerton
Address: Still Pond, Md.
19. Mar 10 1947 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1947, at 9:54 M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2-22-47 1947, to 3-8 1947
and that I last saw her alive on 3-8-47 1947

Immediate cause of death	DURATION
Intracranial hemorrhage	14 days
Due to: Arterial hypertension	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. Ted Dare M. D. or other
Address: Chestertown Md Date signed: 3-10-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

02937

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 2040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kent
City or town: Turner, Chestertown R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Turner Chestertown R.F.D.
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Edward C Jones

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Rachel E. Wallace
6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.): October 7, 1878

8. AGE: Years	Months	Days	If less than one day
68	5	4	hrs. min.

9. Birthplace: Hungars Delaware
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Abraham Jones
13. Birthplace: Hungars Delaware
MOTHER 14. Maiden name: Josephine Hemlow
15. Birthplace: Delaware
16. Informant: Mrs. Ed. Jones
Address: Chestertown.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-13-47 (mouth) (day) (year)
Cemetery or crematory: Kahana
Location: Kahana Maryland
16. Funeral director: J. Willis Wells
Address: Chestertown, Maryland

19. Mar 12 1947 (Date rec'd by registrar) F. A. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1947, at 2:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946, to March 10 1947
and that I last saw h[illegible] alive on March 10 1947

Immediate cause of death	DURATION
Asphyxia	3 days
Due to: Cardiac Varement	
Due to: Nerves	2 Years
Other conditions	

(Includes pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, pubitc place (where?)
Means of injury: injured at work?

23. SIGNATURE: F. A. Smith M. D. or other
Address: Chestertown Date signed 3/14/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

02938

CERTIFICATE OF DEATH

Reg. Dist. No. 2001

1. PLACE OF DEATH:
County: Kent
City or town: Massey Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Kent
City or town: Massey
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Russell Kelly

3.(b) Social Security Number: 716-01-3147

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Evelyn P Kelly
6.(c) If alive, give age: 41 years
7. Birth date of deceased (mo., day, yr.): March 9 1902
8. AGE: Years: 45 Months: 0 Days: 3 If less than one day: hrs. min.
9. Birthplace: Kent Co. Md. (Town, county, and state)
10. Usual occupation: Gas Welder P.R.R.
11. Industry or business
FATHER 12. Name: Hess Kelly
13. Birthplace: Md.
MOTHER 14. Maiden name: Lydia Woolman
15. Birthplace: Md.
16. Informant: Evelyn P Kelly
Address: Massey Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 1947 (month) (day) (year)
Cemetery or crematory: Massey
Location: Massey Md
18. Funeral director: Edward Fellows
Address: Millington Md
19. March 19, 1947 (Date rec'd by registrar) Edward L Fellows Registrar Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 1947, at 2 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8 1947, to March 12 1947
and that I last saw h alive on March 12 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G. C. Bafford M. D. or other
Address: Millington Date signed March 19 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

02939

Reg. Dist. No. 203

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years

Hospital, institution, or street address where death occurred: Havens

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Havens
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Tillard Mc Clary

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	married

6.(b) Name of husband or wife: Emora Mc Clary

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Dec 23 1873

8. AGE:

Years	Months	Days	If less than one day
73	2	18	...hrs. ...min.

9. Birthplace: Tillsbord, Md
(Town, county, and state)

10. Usual occupation: retired

11. Industry or business: —

FATHER
12. Name: Joshua Mc Clary
13. Birthplace: not known

MOTHER
14. Maiden name: Susie May Anderson
15. Birthplace: Wilmington, Del

16. Informant: Wm. Mc Clary
Address: Rock Hall, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 13 1947 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: Rock Hall Md

18. Funeral director: Edgar L. Lane

Address: Kennedyville Md

19. 3/12 1947 (Date rec'd by registrar) J. Elwood Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1947, at 10 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26 1947, to March 10 1947 and that I last saw h.. alive on March 10 1947

Immediate cause of death	DURATION
Chron Int & Myocarditis	
Concussion of the brain	
Due to: Fall from roof	
Due to: Bronchitis	
Other conditions: Deaf-Dumb-blind	
Mental deficiency (arteriosclerotic).	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide~~, or ~~homicide~~ Feb 26 /47 Date of 2/26/47

Where did injury occur? Rock Hall (City or town) Kent (County) Md (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: Fall from Roof injured at work? no

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall, Md Date signed: 3/10/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2 - 2 5 -

02940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2022

1. PLACE OF DEATH:
County: Kent
City or town: Lynch
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 yrs.
Hospital, institution, or street address where death occurred: Lynch
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Lynch
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Lynch
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Thomas John Olivia

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: (Late) Ruth A. Olivia
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 23 1856

8. AGE:

Years	Months	Days	If less than one day
90	7	0	..... hrs. ..... min.

9. Birthplace: Hartford Co. Maryland
(Town, county, and state)
10. Usual occupation: Canner Retired
11. Industry or business: Packing Tomatoes
FATHER 12. Name: William Olivia
13. Birthplace: Scotland
MOTHER 14. Maiden name: Sarah Mac Coy
15. Birthplace: Scotland
18. Informant: Miss Margaut Olivia (daughter)
Address: Lynch, Kent Co. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 26, 1947 (month) (day) (year)
Cemetery or crematory: St. Marys
Location: Emmorton Harford Co. Md.
18. Funeral director: Mavis V. Williams
Address: Chestertown, Maryland.
19. March 25 1947 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23 1947, at 1:00 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1946, to Mar 22 1947
and that I last saw h[illegible] alive on Mar 22 1947

Immediate cause of death	DURATION
(a) Cerebral Hemorrhage	5 hrs
Due to (b) Intestinal Gas	2 yrs
Due to (c)	
Other conditions: General Edema	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Lewis A Smith M. D. or other
Address: Chestertown Date signed 3/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

02943

Reg. Dist. No. 2102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Kent & Queen Anne's Co Hospital
How long in hospital or Institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: ~~Ches~~ Kennedyville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Wesley Piner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Mattie Coleman
6.(c) If alive, give age: ~~58~~ years
7. Birth date of deceased (mo., day, yr.): Unknown 1889

8. AGE: Years	Months	Days	If less than one day
58			hrs. min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm

FATHER
12. Name: Alec Piner
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Deceased
Address: Kennedyville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 29 1947 (month) (day) (year)
Cemetery or ~~crematory~~: Colemans
Location: Worton Md Rural
18. Funeral director: B R Fellows
Address: Still Pond Md.

19. Mar. 28 1947 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-25 19 47, at ~~8~~ 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-12 19 47, to 3-25 19 47
and that I last saw h~~im~~ alive on 3-25 19 47

Immediate cause of death	DURATION
gangrene - left leg & foot	13 days
Due to: Diabetes mellitus	unknown
Arteriosclerosis characterized	
Due to: by gangrene in adequate peripheral	
arterial circulation	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Amputation of left leg - mid thigh
Date of op. 3-27-47

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R Lee Wan M. D. or other
Address: Chestertown, Md. Date signed 3-28-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-1)

CERTIFICATE OF DEATH

D-(B2941

Reg. Diat. No. 2020

1. PLACE OF DEATH:

County: Kent

City or town: Pomona

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred: Pomona- Chestertown RD #3

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Pomona

(If outside city or town limits, write RURAL and give nearest town)

Street No. Chestertown R.D. #3

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Alfred Ringgold

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Widowed

6.(b) Name of husband or wife: (late) Mary Eliz. Ringgold

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 5 1851

8. AGE:

Years	Months	Days	If less than one day
96	0	2	..... hrs. ..... min.

9. Birthplace: Pomona, Kent Co. Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Yard Man

FATHER

12. Name: George Ringgold

13. Birthplace: Quaker Neck, Kent Co. Md.

MOTHER

14. Maiden name: Louise Sipt

15. Birthplace: Quaker Neck, Kent Co. Md.

16. Informant: Casper Brown

Address: R.D. #3 Chestertown, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 9 1947 (month) (day) (year)

Cemetery or crematory: Quaker Neck

Location: Pomona, Kent Co. Maryland

16. Funeral director: Maurice V. Williams

Address: Chestertown Maryland

19. March 9, 1947 (Date rec'd by registrar) Clara A. Barnes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 1947, at 4:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 1947, to March 7 1947 and that I last saw h.. alive on March 7 1947

	DURATION
Immediate cause of death: old age	
Chron Endo – Myocarditis	
Due to: Pneumonia Both Lungs	
Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of .....

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury: — Injured at work? —

23. SIGNATURE: Albert A. Bussard M. D. or other

Address: Rock Hall Md. Date signed 3/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16-B)

CERTIFICATE OF DEATH

1:2942

Reg. Dist. No. 2030

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Kent

City or town: Chestertown, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: James Junior Shaw

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 20, 1947

8. AGE:

Years	Months	Days	If less than one day
		9	hrs. min.

9. Birthplace: Chestertown, Kent Co., Md.

(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER — 12. Name: James Shaw

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Doris Emily Butler

15. Birthplace: Rock Hall, Md.

16. Informant: Doris E. Butler

Address: Rock Hall, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 31, 1947 (month) (day) (year)

Cemetery or crematory: Sharptown (Col.) Cemetery

Location: near Rock Hall-Kent Co. Md.

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. 3/31 (Date rec'd by registrar) 1947 S. Elwood Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-29 1947 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-20 1947, to 3-28 1947 and that I last saw him alive on 3-28-47 1947

Immediate cause of death	Duration
Emphysema (pneumothorax?)	36 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. Burt W. Farr M. D.

Address: Chestertown, Md. Date signed: 3-29-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02944

Reg. Dist. No. 2102

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Kent and Queen Anne Co. Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: kent

City or town: Fairlee
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Henry G. Watson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Amelia Brown Watson

6.(c) If alive, give age: living years

7. Birth date of deceased (mo., day, yr.): Feb. I7, I879

8. AGE: Years	Months	Days	If less than one day
68	I	I2	hrs. min.

9. Birthplace: Seneca County, Ohio
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: James Wesley Watson
13. Birthplace: Fostoria, Ohio

MOTHER — 14. Maiden name: Anna Burns
15. Birthplace: Ohio

16. Informant: Mrs. Amelia Watson (wife)
Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 3I, I947 (month) (day) (year)

Cemetery or crematory: Saint Paul Cem.

Location: near - Fairlee Kent Co. Md.

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. March 30, 1947 (Date rec'd by registrar) Clara L. Barnes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1947, at 2.25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945, to March 28 1947 and that I last saw h[illegible] alive on March 28 1947

	DURATION
Immediate cause of death: Cardio Vascular Disease	
Due to: Malignant Hypertension	1 yrs
Due to: Arterio Sclerosis	2 yrs
Other conditions: Uremia Toxemia	6 mos

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Francis Smith M. D. or other

Address: Chestertown Date signed: 3/29/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1—35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02945

Reg. Dist. No. 204

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Kent

City or town: Sandy Bottom

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown R.D. No 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Addie Hodges Wicker

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	widow

6.(b) Name of husband or wife: Sherman Wicker

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: 65 | Months: - | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Kent Co. Md

(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: Thomas Hodges

13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

15. Birthplace: -

16. Informant: Emma Lomax Daughter

Address: Chestertown R 2 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 20 1947 (month) (day) (year)

Cemetery or crematory: Sandy Bottom

Location: " "

18. Funeral director: A. Lowry Henry

Address: Chestertown Md

19. March 19 1947 (Date rec'd by registrar) F. W. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 1947, at 9 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19.., to March 20 1947

and that I last saw her alive on March 20 1947

Immediate cause of death	DURATION
Cerebral Apoplexy	2 hrs
Due to: Hypertension	4 years
Other conditions: Cancer	2 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank W. Smith M. D. or Other

Address: Chestertown Date signed: 3/25/47

1 - 35 -

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-D)

CERTIFICATE OF DEATH

02946

Reg. Dist. No. 2030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Kent

City or town Rock Hall R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME A. Carroll Willson

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife Gertrude H. Willson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1860

8. AGE: Years	Months	Days	If less than one day
86	4	25	..... hrs. ..... min.

9. Birthplace Kent Co. Maryland (town, county, and state)

10. Usual occupation farmer

11. Industry or business farm

FATHER

12. Name Alexander Willson

13. Birthplace Kent Co. Maryland

MOTHER

14. Maiden name Mary Tilden

15. Birthplace Kent Co. Maryland

16. Informant J. Ernest Willson (son)

Address Rock Hall, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 9, 1947 (month) (day) (year)

Cemetery or crematory ~~Chester~~ Saint Paul Cem.

Location near - Chestertown, Maryland

18. Funeral director J. Willis Wells

Address Chestertown, Maryland

19. March 8. 1947 (Date rec'd by registrar) A. Elwood Burgard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947, at 4 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 13 1946, to March 6 1947

and that I last saw h~~im~~ alive on March 1 1947

Immediate cause of death	DURATION
Chron Endo-Myocarditis	
Cerebral Hemorrhage	
Due to Paralysis Agitans	
arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Albert A Burgard M. D. or other

Address Rock Hall, Md Date signed 3/7/47

1-35